

111TH CONGRESS  
1ST SESSION

# S. 1307

To amend part C of title XVIII of the Social Security Act with respect to Medicare special needs plans and the alignment of Medicare and Medicaid for dually eligible individuals, and for other purposes.

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## IN THE SENATE OF THE UNITED STATES

JUNE 19, 2009

Mr. FEINGOLD (for himself and Ms. KLOBUCHAR) introduced the following bill; which was read twice and referred to the Committee on Finance

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## A BILL

To amend part C of title XVIII of the Social Security Act with respect to Medicare special needs plans and the alignment of Medicare and Medicaid for dually eligible individuals, and for other purposes.

1       *Be it enacted by the Senate and House of Representa-*  
2       *tives of the United States of America in Congress assembled,*

### 3   **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4       (a) **SHORT TITLE.**—This Act may be cited as the  
5       “Medicare Specialty Care Improvement and Protection  
6       Act of 2009”.

7       (b) **TABLE OF CONTENTS.**—The table of contents of  
8       this Act is as follows:

- Sec. 1. Short title; table of contents.
- Sec. 2. Extension of SNP authority.
- Sec. 3. Improve risk adjustment for high-risk, high-cost beneficiaries.
- Sec. 4. Additional enhancements to ensure payment equity for specialized MA plans.
- Sec. 5. Advance alignment of Medicare and Medicaid for dual eligibles.
- Sec. 6. Medicaid presumptive eligibility option.
- Sec. 7. Extension of prescription drug discounts to enrollees of Medicaid managed care organizations.
- Sec. 8. Definitions.

**1 SEC. 2. EXTENSION OF SNP AUTHORITY.**

2 Section 1859(f)(1) of the Social Security Act (42  
3 U.S.C. 1395w-28(f)(1)), as amended by section 164(a) of  
4 the Medicare Improvements for Patients and Providers  
5 Act of 2008 (Public Law 110-275), is amended—

6 (1) by striking “2011” and inserting “2014”;  
7 and

8 (2) by adding at the end the following new sen-  
9 tence: “In the case of a specialized MA plan for spe-  
10 cial needs individuals that is designated as a Fully  
11 Integrated Dual Eligible Special Needs Plan under  
12 section 5(a)(1) of the Medicare Specialty Care Im-  
13 provement and Protection Act of 2009, the pre-  
14 ceding sentence shall be applied by substituting  
15 ‘2016’ for ‘2014’.”.

**16 SEC. 3. IMPROVE RISK ADJUSTMENT FOR HIGH-RISK, HIGH-  
17 COST BENEFICIARIES.**

18 (a) EVALUATION.—

19 (1) IN GENERAL.—The Secretary shall evaluate  
20 the Medicare Advantage risk adjustment payment

1 mechanism under section 1853(a)(1)(C) of the So-  
 2 cial Security Act (42 U.S.C. 1395w-23(a)(1)(C))  
 3 and the risk adjustment payment mechanism under  
 4 section 1860D-15(c)(1)(A) of such Act (42 U.S.C.  
 5 1395w-115(c)(1)(A)) in order to resolve plan pay-  
 6 ment inequities relative to Medicare fee-for-service  
 7 payments for beneficiaries identified under para-  
 8 graph (2).

9 (2) REQUIREMENTS.—The evaluation conducted  
 10 under paragraph (1) shall address the need for im-  
 11 proving the adequacy of the existing hierarchical  
 12 condition categories and pharmacy risk adjustment  
 13 methods for Medicare Advantage plans that exclu-  
 14 sively or disproportionately serve high-risk bene-  
 15 ficiaries as it relates to—

16 (A) accurately predicting costs relative to  
 17 Medicare fee-for-service for beneficiaries with—

18 (i) sustained high-risk scores over  
 19 multiple contract periods;

20 (ii) sustained high costs over multiple  
 21 contract periods;

22 (iii) co-morbid chronic conditions;

23 (iv) diagnoses not included in the risk-  
 24 adjustment methodology, including demen-  
 25 tia and other cognitive impairments;

1 (v) physical disabilities, developmental  
 2 disabilities, or both; and

3 (vi) frailty;

4 (B) accurately predicting costs relative to  
 5 Medicare fee-for-service for beneficiaries near  
 6 the end of life;

7 (C) accurately predicting costs relative to  
 8 Medicare fee-for-service for other conditions for  
 9 which the current risk adjustment methodology  
 10 underpays in relation to Medicare fee-for-serv-  
 11 ice, as determined by the Secretary;

12 (D) further gradations of diseases and con-  
 13 ditions to better reflect stage of condition, con-  
 14 dition severity, and costs related to burden of  
 15 illness;

16 (E) accounting for costs of pre-existing  
 17 conditions at the time of initial enrollment for  
 18 new entrants into Medicare; and

19 (F) enhancing coding persistency by calcu-  
 20 lating risk scores using data covering at least 2  
 21 years.

22 (b) USE OF THE RESULTS OF THE STUDY FOR RE-  
 23 FINEMENTS.—

24 (1) REFINEMENTS.—

1 (A) IN GENERAL.—Beginning with plan  
2 year 2011, the Secretary, using the results of  
3 the evaluation conducted under subsection  
4 (a)(1), shall refine the risk adjustment payment  
5 mechanisms referred to in subsection (a)(1) for  
6 beneficiaries identified under subsection (a)(2).  
7 The Secretary shall make additional refine-  
8 ments, as appropriate, for subsequent plan  
9 years.

10 (B) PROTECTION.—To the extent that the  
11 Secretary determines that the risk adjustment  
12 payment mechanisms referred to in subsection  
13 (a)(1) do not accurately pay for Medicare bene-  
14 ficiaries identified under subsection (a)(2), the  
15 Secretary shall ensure that a Medicare Advan-  
16 tage plan that exclusively or disproportionately  
17 serves high-risk beneficiaries is not paid less, in  
18 the aggregate, than 100 percent of Medicare  
19 fee-for-service payment rates (as determined  
20 under section 1853(c)(1)(D)(i)).

21 (C) RECALIBRATION.—Beginning with  
22 plan year 2011, the Secretary shall recalibrate  
23 the risk adjustment payment mechanisms re-  
24 ferred to in subsection (a)(1) so that the overall  
25 predicted costs for all Medicare beneficiaries are

1 identical to what they would have been in the  
 2 absence of the new risk adjustment payment  
 3 mechanism.

4 (2) BUDGET NEUTRAL ADJUSTMENTS.—If the  
 5 Secretary determines that the application of para-  
 6 graph (1) results in expenditures under title XVIII  
 7 of the Social Security Act that exceed the expendi-  
 8 tures under such title that would have been made  
 9 without such application, the Secretary shall provide  
 10 for an appropriate adjustment to payment rates  
 11 under part C of such title for beneficiaries for whom  
 12 the risk adjustment payment mechanism overpays in  
 13 relation to Medicare fee-for-service in order to elimi-  
 14 nate such excess.

15 **SEC. 4. ADDITIONAL ENHANCEMENTS TO ENSURE PAY-**  
 16 **MENT EQUITY FOR SPECIALIZED MA PLANS.**

17 (a) ACCOUNTING FOR ADDED REGULATORY  
 18 COSTS.—For plan year 2011 and subsequent plan years,  
 19 the Secretary shall provide bonus payments to account for  
 20 added SNP costs associated with additional benefit, care  
 21 management, reporting, and other requirements estab-  
 22 lished by Congress and the Secretary in excess of other  
 23 Medicare Advantage plans.

24 (b) ENSURING FAIR BIDDING PRACTICES.—For plan  
 25 year 2011 and subsequent plan years, the Secretary shall

1 take into account the following factors with respect to the  
2 bid structure for SNPs:

3 (1) Dual eligibility.

4 (2) Geographic cost differences.

5 (3) Population characteristics.

6 (4) The differences in plan requirements, in-  
7 cluding differences in additional benefits, care man-  
8 agement, and reporting requirements.

9 (5) The differences between community-based  
10 and regional or nationally based plans.

11 (c) AUTHORITY TO APPLY PACE RULES.—For plan  
12 year 2011 and subsequent plan years, the Secretary may  
13 apply the payment rules under section 1894(d) of the So-  
14 cial Security Act (42 U.S.C. 1395eee(d)) to Fully Inte-  
15 grated Dual Eligible Special Needs Plans rather than the  
16 payment rules that would otherwise apply to such plans  
17 under part C.

18 (d) BUDGET NEUTRAL ADJUSTMENTS.—If the Sec-  
19 retary determines that the application of subsections (a),  
20 (b), and (c) result in expenditures under title XVIII of  
21 the Social Security Act that exceed the expenditures under  
22 such title that would have been made without such appli-  
23 cation, the Secretary shall provide for an appropriate ad-  
24 justment to payment rates under part C of such title for  
25 beneficiaries for whom the risk adjustment payment mech-

1 anism overpays in relation to Medicare fee-for-service in  
 2 order to eliminate such excess.

3 **SEC. 5. ADVANCE ALIGNMENT OF MEDICARE AND MED-**  
 4 **ICAID FOR DUAL ELIGIBLES.**

5 (a) MEDICARE AND MEDICAID INTEGRATION PRO-  
 6 GRAMS.—

7 (1) DESIGNATION.—

8 (A) IN GENERAL.—For plan year 2011  
 9 and subsequent plan years, the Secretary shall  
 10 have in place a process under which the Sec-  
 11 retary designates dual eligible SNPs as Fully  
 12 Integrated Dual Eligible Special Needs Plans  
 13 for the purpose of advancing fully integrated  
 14 Medicare and Medicaid benefits and services for  
 15 dual beneficiaries, including State designated  
 16 Dual subsets.

17 (B) CRITERIA FOR DESIGNATION.—In  
 18 order to be designated as a Fully Integrated  
 19 Dual Eligible Special Needs Plan, the dual eli-  
 20 gible SNP shall meet the following require-  
 21 ments:

22 (i) The dual eligible SNP provides  
 23 dual eligibles with access to Medicare and  
 24 Medicaid benefits specified by the State for  
 25 Medicaid beneficiaries enrolled in inte-



1           grated programs under a single managed  
2           care organization (MCO).

3           (ii) The dual eligible SNP has a con-  
4           tract in place with a State Medicaid agency  
5           that includes coverage of specified primary,  
6           acute, and long-term care benefits and  
7           services, consistent with State policy,  
8           under risk-based financing.

9           (iii) The dual eligible SNP coordinates  
10          the delivery of covered Medicare and Med-  
11          icaid health and long-term care services,  
12          consistent with State policy, using aligned  
13          care management and specialty care net-  
14          work methods for high-risk beneficiaries.

15          (iv) The dual eligible SNP employs  
16          policies and procedures approved by the  
17          Secretary and the State to coordinate or  
18          integrate enrollment, member materials,  
19          communications, grievance and appeals,  
20          and quality assurance.

21          (v) The dual eligible SNP provides ad-  
22          vanced person-centered, integrated care for  
23          the full array of primary, acute, and resi-  
24          dential and home and community-based

1 long-term care services, using a robust ad-  
 2 vanced medical home model that—

3 (I) empowers dual eligibles with  
 4 serious chronic conditions and their  
 5 family caregivers to optimize their  
 6 health and well-being;

7 (II) provides a comprehensive  
 8 array of patient-centered benefits and  
 9 services designed to meet the unique  
 10 needs of dual eligibles;

11 (III) helps dual eligibles and  
 12 their family caregivers to access the  
 13 right care, at the right time, in the  
 14 right place, given the nature of their  
 15 condition;

16 (IV) aligns the incentives of re-  
 17 lated care providers to improve transi-  
 18 tions and care continuity; and

19 (V) optimizes total quality and  
 20 cost performance across time, place,  
 21 and profession.

22 (2) INTEGRATION AUTHORITY.—In order to in-  
 23 crease simplicity for dual eligibles in accessing and  
 24 coordinating Medicare and Medicaid benefits, the  
 25 Secretary, working in conjunction with States, on a

1 State by State basis, consistent with existing statu-  
2 tory authority, is encouraged to establish a single  
3 administrative structure and process under titles  
4 XVIII and XIX for Fully Integrated Dual Eligible  
5 Special Needs Plans, under a three-way contract or  
6 Memorandum of Understanding, among CMS, the  
7 State, and related plans, for—

8 (A) the enrollment of dual eligibles;

9 (B) member materials and related commu-  
10 nications;

11 (C) care management and model of care  
12 requirements;

13 (D) reporting, auditing, and performance  
14 evaluation;

15 (E) grievance and appeals procedures; and

16 (F) payment methods.

17 (3) ALIGNMENT OF MEDICARE AND MEDICAID  
18 POLICIES AND PROCEDURES FOR SNPS SERVING  
19 DUAL ELIGIBLES.—In order to increase simplicity  
20 for dual eligibles in accessing and coordinating  
21 Medicare and Medicaid benefits by enhancing coordi-  
22 nation between CMS and State Medicaid agencies in  
23 the oversight of SNPs insofar as they serve dual eli-  
24 gibles, the Secretary, working in collaboration with  
25 State Medicaid agencies, may modify rules, policies,

1 and procedures under titles XVIII and XIX of such  
2 Act in order to provide for the alignment of Medi-  
3 care and Medicaid requirements, including mar-  
4 keting, enrollment, care coordination, auditing, re-  
5 porting, quality assurance, and other relevant over-  
6 sight functions.

7 (4) REPORTS TO CONGRESS.—

8 (A) INTERIM REPORT.—Not later than De-  
9 cember 31, 2013, the Secretary shall submit to  
10 Congress an interim report on the impact of in-  
11 tegrating Medicare and Medicaid benefits and  
12 services on total quality and cost performance  
13 in serving dual eligibles.

14 (B) FINAL REPORT.—Not later than De-  
15 cember 31, 2015, the Secretary shall submit to  
16 Congress a final report on the impact of inte-  
17 grating Medicare and Medicaid benefits and  
18 services on total quality and cost performance  
19 in serving dual eligibles.

20 (C) REQUIREMENT.—A report under sub-  
21 paragraph (A) and (B) shall include rec-  
22 ommendations for such legislative and adminis-  
23 trative actions as the Secretary determines ap-  
24 propriate to further advance Medicare and Med-  
25 icaid integration, including options for inte-

grating Medicare and Medicaid funding, to facilitate ongoing improvements in total quality and cost performance in care of dual eligibles.

(D) QUALITY AND COST PERFORMANCE.—

Not later than 6 months after the date of the enactment of this Act, the Secretary, working in consultation with consumers, plans, and States, shall identify the measures and benchmarks to be used for evaluating cost and quality performance for purposes of subparagraph (C).

(b) OFFICE OF MEDICARE/MEDICAID INTEGRATION.—

(1) ESTABLISHMENT.—The Secretary shall establish or designate an Office on Medicare/Medicaid Integration (in this subsection referred to as the “Office”) for the purpose of aligning Medicare and Medicaid policies and procedures and developing tools to support State integration efforts in order to—

(A) simplify dual eligible access to Medicare and Medicaid benefits and services;

(B) improve care continuity and ensure safe and effective care transitions;

1 (C) eliminate cost shifting between Medi-  
2 care and Medicaid and among related care pro-  
3 viders;

4 (D) eliminate regulatory conflicts between  
5 Medicare and Medicaid rules; and

6 (E) improve total cost and quality per-  
7 formance.

8 (2) RESPONSIBILITIES.—The responsibilities of  
9 the Office are to develop policies and procedures  
10 to—

11 (A) oversee the designation, implementa-  
12 tion, and oversight of Fully Integrated Dual El-  
13 igible Special Needs Plans under subsection  
14 (a)(1) in collaboration with the States, with au-  
15 thority to effectively align Medicare and Med-  
16 icaid policy for dual eligibles;

17 (B) provide State Medicaid agencies with  
18 training, materials, technical assistance, and  
19 other resources in support of advancing Medi-  
20 care and Medicaid integration in States where  
21 Fully Integrated Dual Eligible Special Needs  
22 Plans have been designated and other integra-  
23 tion initiatives are being advanced to coordinate  
24 and align primary, acute, and long-term care

1 benefits for dual eligibles through a State plan  
2 option or other means;

3 (C) identify incentives for States to ad-  
4 vance the integration of Medicare and Medicaid  
5 to improve total cost and quality performance,  
6 including shared cost savings among consumers,  
7 plans, and Federal and State governments with  
8 respect to State initiatives for advancing Medi-  
9 care and Medicaid integration;

10 (D) support State efforts to coordinate and  
11 align acute and long-term care benefits for dual  
12 eligibles through a State plan option or other  
13 means;

14 (E) provide support for coordination of  
15 State and Federal contracting and oversight for  
16 dual integration programs supportive of the  
17 goals described in paragraph (1);

18 (F) align Federal rules for Medicaid man-  
19 aged care and Medicare Advantage Plans to in-  
20 clude methods for integrating marketing, enroll-  
21 ment, grievances and appeals, auditing, report-  
22 ing, quality assurance, and other relevant over-  
23 sight functions;

24 (G) serve as a liaison between CMS central  
25 and regional offices to ensure consistent appli-

1 cation of CMS rules, policies, and auditing  
2 practices as such rules, policies, and auditing  
3 practices pertain to dual eligibles;

4 (H) monitor total combined Medicare and  
5 Medicaid costs in serving dual eligibles and  
6 make recommendations for optimizing total  
7 quality and cost performance across both pro-  
8 grams; and

9 (I) work with the Congressional Budget  
10 Office and the Office of Management and  
11 Budget to establish a process for evaluating  
12 total Medicare and Medicaid spending for dual  
13 eligibles who are enrolled in Fully Integrated  
14 Dual Eligible Special Needs Plans such that the  
15 enrollment of such dual eligibles in such plans  
16 is treated as “budget neutral” if the combined  
17 Medicare and Medicaid costs under such plans  
18 do not exceed the combined costs of providing  
19 Medicare and Medicaid services on a fee-for-  
20 service basis for a comparable risk group.

21 (3) FUNDING FROM SAVINGS.—

22 (A) IN GENERAL.—For purposes of fund-  
23 ing for the Office, there shall be made available  
24 for each of fiscal years 2010 through 2014,



1           \$2,000,000 from the savings described in sub-  
2           paragraph (B).

3           (B) SAVINGS.—The savings described in  
4           this subparagraph are the average per capita  
5           savings described in paragraphs (3)(C) and  
6           (4)(C) of section 1854(b) for which monthly re-  
7           bates are provided under section 1854(b)(1)(C)  
8           in the fiscal year involved.

9           (C) AVAILABILITY.—Funds made available  
10          under this paragraph shall be transferred to the  
11          Secretary from the Federal Hospital Insurance  
12          Trust Fund under section 1817 of the Social  
13          Security Act (42 U.S.C. 1395i) and the Federal  
14          Supplementary Insurance Trust Fund under  
15          section 1841 of such Act (42 U.S.C. 1395t) in  
16          the proportion specified in section 1853(f) of  
17          such Act (42 U.S.C. 1395w–23(f)).

18 **SEC. 6. MEDICAID PRESUMPTIVE ELIGIBILITY OPTION.**

19          (a) IN GENERAL.—Section 1902(e) of the Social Se-  
20          curity Act (42 U.S.C. 1396a(e)) is amended by adding at  
21          the end the following:

22          “(14) At the option of the State, the plan may pro-  
23          vide for a period of presumptive eligibility for an individual  
24          who has attained age 65, who has 12 or more consecutive  
25          months of eligibility under this title, and who the State

1 has reason to believe will be determined to be a full-benefit  
 2 dual eligible individual (as defined in section 1935(c)(6)),  
 3 but only if the State—

4 “(A) agrees to randomly conducted eligibility  
 5 audits by the Secretary; and

6 “(B) ensures that any individual enrolled under  
 7 the State plan who is determined to be ineligible for  
 8 medical assistance as a result of such an audit (and,  
 9 if such individual is enrolled in a specialized MA  
 10 plan for special needs individuals under part C of  
 11 title XVIII, ensures that the organization offering  
 12 such plan) is notified at least 30 days prior to the  
 13 date on which the individual is disenrolled from the  
 14 State plan.”.

15 (b) EFFECTIVE DATE.—The amendment made by  
 16 subsection (a) takes effect on January 1, 2010.

17 **SEC. 7. EXTENSION OF PRESCRIPTION DRUG DISCOUNTS**  
 18 **TO ENROLLEES OF MEDICAID MANAGED**  
 19 **CARE ORGANIZATIONS.**

20 (a) IN GENERAL.—Section 1903(m)(2)(A) of the So-  
 21 cial Security Act (42 U.S.C. 1396b(m)(2)(A)) is amend-  
 22 ed—

23 (1) in clause (xi), by striking “and” at the end;

24 (2) in clause (xii), by striking the period at the  
 25 end and inserting “; and”; and

1 (3) by adding at the end the following:

2 “(xiii) such contract provides that (I)  
3 payment for covered outpatient drugs dis-  
4 pensed to individuals eligible for medical  
5 assistance who are enrolled with the entity  
6 shall be subject to the same rebate re-  
7 quired by the agreement entered into  
8 under section 1927 as the State is subject  
9 to, and (II) capitation rates paid to the en-  
10 tity shall be based on actual cost experi-  
11 ence related to rebates and subject to the  
12 Federal regulations requiring actuarially  
13 sound rates.”.

14 (b) CONFORMING AMENDMENTS.—Section 1927 of  
15 the Social Security Act (42 U.S.C. 1396r–8) is amended—

16 (1) in subsection (d)—

17 (A) in paragraph (1), by adding at the end  
18 the following:

19 “(C) Notwithstanding the subparagraphs  
20 (A) and (B)—

21 “(i) a Medicaid managed care organi-  
22 zation with a contract under section  
23 1903(m) may exclude or otherwise restrict  
24 coverage of a covered outpatient drug on  
25 the basis of policies or practices of the or-

1           ganization, such as those affecting utiliza-  
2           tion management, formulary adherence,  
3           and cost sharing or dispute resolution, in  
4           lieu of any State policies or practices relat-  
5           ing to the exclusion or restriction of cov-  
6           erage of such drugs, provided, however,  
7           that any such exclusions and restrictions of  
8           coverage shall be subject to any contrac-  
9           tual requirements and oversight by the  
10          State as contained in the Medicaid man-  
11          aged care organization's contract with the  
12          State, and the State shall maintain ap-  
13          proval authority over the formulary used  
14          by the Medicaid managed care organiza-  
15          tion; and

16               “(ii) nothing in this section or para-  
17          graph (2)(A)(xiii) of section 1903(m) shall  
18          be construed as requiring a Medicaid man-  
19          aged care organization with a contract  
20          under such section to maintain the same  
21          such policies and practices as those estab-  
22          lished by the State for purposes of individ-  
23          uals who receive medical assistance for cov-  
24          ered outpatient drugs on a fee-for-service  
25          basis.”; and

1 (B) in paragraph (4), by inserting after  
2 subparagraph (E) the following:

3 “(F) Notwithstanding the preceding sub-  
4 paragraphs of this paragraph, any formulary  
5 established by Medicaid managed care organiza-  
6 tion with a contract under section 1903(m) may  
7 be based on positive inclusion of drugs selected  
8 by a formulary committee consisting of physi-  
9 cians, pharmacists, and other individuals with  
10 appropriate clinical experience as long as drugs  
11 excluded from the formulary are available  
12 through prior authorization, as described in  
13 paragraph (5).”; and

14 (2) in subsection (j), by striking paragraph (1)  
15 and inserting the following:

16 “(1) Covered outpatients drugs are not subject  
17 to the requirements of this section if such drugs  
18 are—

19 “(A) dispensed by health maintenance or-  
20 ganizations, including Medicaid managed care  
21 organizations that contract under section  
22 1903(m); and

23 “(B) subject to discounts under section  
24 340B of the Public Health Service Act.”.

1       (c) REPORTS.—Each State with a contract with a  
 2 Medicaid managed care organization under section  
 3 1903(m) of the Social Security Act (42 U.S.C. 1396b(m))  
 4 shall report to the Secretary on a quarterly basis the total  
 5 amount of rebates in dollars and volume received from  
 6 manufacturers (as defined in section 1927(k)(5) of such  
 7 Act (42 U.S.C. 1396r–8(k)(5)) for drugs provided to indi-  
 8 viduals enrolled with such an organization as a result of  
 9 the amendments made by this section for both brand-name  
 10 and generic drugs. The Secretary shall review the reports  
 11 submitted by States under this subsection and, after such  
 12 review, make publically available the aggregate data con-  
 13 tained in such reports.

14       (d) EFFECTIVE DATE.—This section and the amend-  
 15 ments made by this section take effect on the date of en-  
 16 actment of this Act and apply to rebate agreements en-  
 17 tered into or renewed under section 1927 of the Social  
 18 Security Act (42 U.S.C. 1396r–8) on or after such date.

19 **SEC. 8. DEFINITIONS.**

20       In this Act:

21           (1) CMS.—The term “CMS” means the Cen-  
 22 ters for Medicare & Medicaid Services.

23           (2) DUAL ELIGIBLE.—The term “dual eligible”  
 24 means an MA eligible individual (as defined in sec-  
 25 tion 1851(a)(3) of the Social Security Act, 42

1 U.S.C. 13195w–21(a)(3)) who is also entitled to  
2 medical assistance under a State plan under title  
3 XIX of the Social Security Act.

4 (3) DUAL ELIGIBLE SNP.—The term “dual eli-  
5 gible SNP” means a SNP described in section  
6 1859(b)(6)(A)(ii) of the Social Security Act.

7 (4) MEDICAID.—The term “Medicaid” means  
8 the program under title XIX of the Social Security  
9 Act.

10 (5) MEDICARE.—The term “Medicare” means  
11 the program under title XVIII of the Social Security  
12 Act.

13 (6) MEDICARE FEE-FOR-SERVICE.—The term  
14 “Medicare fee-for-service” means the original Medi-  
15 care fee-for-service program under parts A and B of  
16 title XVIII of the Social Security Act.

17 (7) SECRETARY.—The term “Secretary” means  
18 the Secretary of Health and Human Services.

19 (8) SNP.—The term “SNP” means a special-  
20 ized MA plan for special needs individuals, as de-  
21 fined in section 1859(b)(6)(A) of the Social Security  
22 Act (42 U.S.C. 1395w–28(b)(6)(A)).

1           (9) STATE.—The term “State” has the mean-  
2           ing given such term for purposes of title XIX of the  
3           Social Security Act.

○